NURSES' VOICE FROM THE FIELD

THE CULTURE OF OPPRESSION IN NURSING

Raymund F. Mamayson, MN, RN[1]

Many of the conflicts in the world today take root from oppression – a state where a person or group has influence and supremacy in economic, military or political affairs, causing disadvantage and subdue those who do not. The conflicts between the Catholic Church and other religions, between the whites and the blacks, between the LGBTQIA community and their heterosexual counterparts, between the government and the citizenry, and between men and women, are just illustrations of systemic oppression. Nursing, despite being a female-dominated profession, is not spared from oppression by those practicing medicine, or by the administration. Yes, nurses are oppressed, and physicians, considered as the more powerful group and have been sided with by administration (Roberts, 2000, as cited in Daiski, 2004), have dominated the health care delivery system and have contributed greatly to the oppressed state of nurses today. But why are nurses oppressed in the first place? What conditions led to this state in the discipline? Who is to blame, and how can nurses get away with it? These are just a few of the questions that need answers and thus, have become the primary motivation behind this paper.

As discussed by Young (1990, as cited in Dubrosky, 2013), nursing is considered a social group diminished or immobilized by a structural phenomenon known as oppression. Nurses who share similar experiences and attributes, is in general, part of an oppressed group in the health care industry. Taking its roots from Nightingale who became obedient to the authority of male physicians, nursing has been, since the beginning, perceived as inferior to the medical profession, which resulted to a structuring within an established hierarchy where physicians are at the top (Roberts, 2010). Based on observation, this oppression persists up to the present time, which can be seen as exploitation in the workplace. For one, nurses are controlled by physicians and the administration to achieve self-directed gains and benefits. Additionally, nurses receive minimal compensation for their work, which is a contentious issue where many nurses could relate to a form of oppression. The problem here though lies not on the oppressed state that plagues the nursing profession, but on the enduring and resilient attribute of nurses who for the longest time have been continuously tolerating oppression. In that view, nurses then are partly to be blamed for not standing up against their oppressors. But are they the liable party?

Boxill (2010) discussed that both oppressors and the oppressed share equal weight concerning the responsibility to resist one's oppression, and it is my opinion that this assertion is true. Physicians and administrators, for instance, have the responsibility to stop the oppression of nurses. Unfortunately, they continue to oppress nurses as they are encouraged by varied factors such as their beliefs, disposition, attitude and twisted psychologies; the presence of opportunities; and the benefits derived from feeling superior, which have all contributed to this state. Today, the lack of respect for nurses in interdisciplinary teams is still present where the main perpetrators are physicians who need to assert their superiority and dominance over nurses. Additionally, even patients whom the nurses care for also oppress them by treating them as *"yaya"* or *"katulong."*

Conversely, nurses have the responsibility to resist oppression. Sadly, nurses often think that there is nothing left to do with the oppression that they suffer and that there is no way out of their oppressed state, a condition known as *"learned helplessness."* Most often than not, they remain silent, which makes it possible for them to be oppressed, creating a dysfunctional cycle. Powerlessness derives from this lack of voice, thus, rendering them unable to become agents of change and correct the status quo. While there may be nurses who resist by frustrating their oppressors, most of the time, the physicians and the administration are always one step ahead and make nurses consider their actions as futile.

Additionally, the resistance among nurses appears as rigidity and hostility, and the results are catastrophic to the entire healthcare delivery system. Hence, nurses again reconsider their resistance and eventually accommodate themselves to oppression. Lastly, because of being the oppressed group for quite some time, nurses, specifically the nursing leaders, have become tired of resisting and have accepted their place in the hierarchy. As a result, they have absorbed the values that the oppressors have,

[1] Correspondence: Faculty, School of Nursing, Saint Louis University, Bonifacio Street, Baguio City 2600; email address: raymund.mamayson@gmail.com

and the outcome is *"horizontal violence,"* where nurses fight amongst themselves. And while they are busy arguing and fighting, the more that they become susceptible to external oppression.

Indeed, physicians, administrators, nurses, and patients alike are to be blamed for the oppression in nursing. However, knowing who is liable does not address the problem. Instead, focusing on the eradication of oppression will solve it. Unfortunately, oppression and the circumstances for which it revolves are much more complex, and it will take some time to achieve this goal fully. Nevertheless, nurses must act now more than ever to end the cycle of oppression in the profession.

To begin with, efforts should primarily be directed to understanding power relations, which, according to Formosa (2015), is the key to any health care system. Guided by Foucault's and Habermas' theories, nurses can recognize power relations in the healthcare industry, as well as the factors surrounding it and the possible steps to address it. An understanding of oppression may pave the way for it to be included in the academic formation of nurses, which is another move that nurses can take. The educational preparation of nurses is of critical importance since Fackler, Chambers, and Bourbonniere (2015) concluded that nurses develop a sense of power through the acquisition of knowledge, experience, and self-confidence, as enhanced by exposure to good mentors. Nurse academicians, then, may take steps by presenting the concept of oppression to students, using a variety of teaching strategies. For instance, a novel approach called *"Theatres of the Oppressed"* may be used. Through methods such as Image Theatre, Cops in the Head and Forum Theatre, the students are able to analyze situations of oppression and work through the problem by engaging in ethical and critical thinking to see the underlying forces impacting a person or situation (Rutten et al., 2010, as cited in Love, 2012).

Moreover, nurses must engage in positive identity development by having a renewed appreciation of their history and attributes (Roberts, 2000). Only then will they be able to develop positive self-esteem, which eventually leads to the formation of a cohesive, effective, and powerful force in the health care industry. Furthermore, nurses can apply the concept of empowerment to increase their power and influence (Kuokkanen & Leino-Kilpi, 2000). Though complex as it may be, a detailed analysis of empowerment and its application to nursing are possible using the critical social theory where nurses are seen as an oppressed group, whose living conditions could be improved by providing opportunities for self-development. Organizational and management theories, whose focus is directed to encouraging individuals to assume responsibility through delegation and decentralization of power, can also be used to make it possible for nurses to act in line with the organization's goals. Lastly, the use of social psychological theories that promote empowerment by looking into individual and environmental factors can lead to nurses having a positive self-identity and social intercourse.

On another note, nurses may work with top-level management to address the discrimination and inequities that nurses experience, which, according to Rooddehghan, ParsaYekta and Nasrabadi (2015) lead to submissiveness that facilitates the oppression of nurses. If efforts are directed to reducing discrimination in the workplace, as well as improving the living conditions and social status of nurses, then oppression will be eradicated and will facilitate the rendition of equal, quality care. Nurses will be inclined to give the quality of care that patients deserve. They will have more time to communicate with their patients, an important element in the heart of nursing. Finally, there would be no need to ration care among patients, nor delegate nursing activities to paraprofessionals or auxiliary staff and family members, so that they could get the job done in time.

In sum, oppression in nursing has a long history, and several groups certainly have something to do with this phenomenon. Oppression is complex, and efforts should be directed in understanding it and in the long run, eradicate it. Though certain activities are currently being done to accomplish this goal, these activities are easier said than done. To understand it, one must engage in research, which is a tedious process that many nurses flee from. Additionally, as a commission controls nursing education in the Philippines, it is not easy to modify the curriculum just to fit in stand-alone courses on oppression. Lastly, empowerment may not be easily realized since nursing leaders who are expected to empower their subordinates are not doing their part. Instead of empowering, they are usually those who oppress other nurses by not fighting for their rights in the health care industry.

Nevertheless, these problems should not hinder nurses from getting away from the clutches of their oppressors. They must incessantly struggle to challenge power and privilege in their practice, just so in the future, they will have the power to advocate for positive outcomes for patients and families. Simultaneously, they can use their power to establish a heterarchical organization where collaboration among colleagues is possible and where they consider themselves as partners who have the same status and positions, to achieve better patient outcomes.

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ABOUT THE AUTHOR

Raymund F. Mamayson, MN, RN, is an Associate Professor at Saint Louis University, Baguio City. He has been teaching in the Nursing program since 2008 and has taught a variety of BSN courses such as palliative and gerontology nursing, as well as in the medical-surgical area. He holds Bachelor's and Master's degree in Nursing and is currently finishing his Doctor of Philosophy in Nursing degree at Saint Louis University. Apart from these, he is also a member of the Philippine Nurses Association, and the Gerontology Nurses Association of the Philippines, Inc., where he serves as the secretary of the GNAP-Cordillera chapter. He is actively involved in activities concerning older person care and research endeavors in the field of Gerontological Nursing.